poliomyelitis, or (*b*) non-organic vomiting appearing at the height of the mother's vomiting, rather than "abortive botulism"?—I am, etc.,

New York. ALEX J. STEIGMAN.

Aureomycin in Treatment of Syphilis

SIR,—I was in Bagdad when Dr. Robert Lees's somewhat acrid letter (December 10, 1949, p. 1352) appeared concerning my paper (November 12, p. 1076) on the action of aureomycin on the dark-field positive lesions of early syphilis, and it was not seen by me until my return to the United Kingdom a short time ago. His criticism seems to be threefold: (1) the action of aureomycin was already known; (2) lack of planning; and (3) premature publication.

When I went to Southern Rhodesia at the end of April, 1949, the effects of aureomycin on syphilis were not generally known and indeed were quite unknown to me, even though I had recently made an exhaustive survey, containing over 230 references, of the previous year's literature on venereal diseases.[1] The pilot studies, however, which I had undertaken jointly concerning its action upon gonococcal and non-gonococcal urethritis[2] had made me resolve to find out for myself at the first opportunity.

The trials were commenced on May 18, 1949, and the paper was written at Zimbabwe during the latter part of June and revised under difficult writing conditions on July 8, when I was conducting a venereal diseases survey in a sparsely populated part of sub-tropical Africa. At this time I was of the opinion that the discovery was original, although I did not expect it would remain so for long. As I subsequently learned, Dr. Earle Moore made reference to his experiences at the Johns Hopkins Hospital (without, however, quoting chapter and verse) at a meeting held in London on May 31.[3] Travelling as I have been, the journals have been quite inaccessible to me over the last eight months.

The article appeared in the *British Medical Journal* on November 12, just over four months after it had been written. By this time Dr. Lees was able to say, "This was already known," although he did not advance any personal knowledge of the subject. It is somewhat ironic that had the publication been actually more premature than it was this criticism could not have been applied in such a manner.

The supply of aureomycin available for the study was limited to 48 capsules. The African is not amenable to follow-up attendance, and I was myself on the move. Under these circumstances it was planned that the study be confined to the immediate effects upon the dark-field positive lesions of early syphilis and be controlled by dark-field examinations—the only scientific method available. Even so nine persons were treated with this small amount, which is a greater number than other reported series.[4] At a later date two other patients were similarly treated, and the satisfactory initial results demonstrated to the Mashonaland Branch of the British Medical Association at Salisbury on October 11, 1949.[5]

Personally I have always felt that pilot studies are of immense value, as they give a lead as to whether more detailed tests based on prolonged observation are worth pursuing. In recent years Britain has lagged badly in the developments of the antibiotics for the treatment of venereal diseases, being apparently content to rely on the statements of our distinguished American colleagues. Desire or initiative to undertake a personal trial often seems to be lacking. In this case, there was nothing to be gained by withholding publication, for there was no further information possible to obtain.

It is agreed, even by Dr. Lees, that aureomycin has some action upon early syphilis, and I adhere to my contention that this discovery "opens up a new field of therapeutic investigation." It now remains for other venereologists to substantiate or refute this in a proper scientific manner rather than by premature deprecation in the medical press.—I am, etc.,

London, W.2. R. R. WILLCOX.

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1 *Bull. Hyg. Lond.*, 1949, **24**, 99.
2 *British Medical Journal*, 1949, **2**, 257.
3 *Brit. J. vener. Dis.*, 1949, **25**, 169.
4 *Proc. Mayo Clin.*, 1948, **23**, 574.
5 *Med. Pr.*, 1949, **222**, 585.

Medical Administrators

SIR,—Recent letters on medical administration have shown an all too common misunderstanding of the work of professional administrators.

No one, I think, would suggest that there is a profession of being a professor. You can only be a professor of some subject. The man who is an excellent professor of history would not necessarily have equal success as a professor of zoology. Similarly, there is no such thing as an administrator but only an administrator of something. You cannot administer any medical organization unless you are yourself trained in medical matters. The medical training alone is not sufficient: other qualities are necessary to the medical administrator in addition, but the professional training is primary and essential. The term "lay administrator" in relation to any professional matter is completely absurd and meaningless.

Perhaps a better analogy is that of the captain of a ship. All men with the technical ability to obtain a master's ticket do not necessarily have those other qualities which make them good commanders, but no one would dream of appointing a lay administrator to run the ship on the bare advice of a technically qualified captain. Technical competence plus a certain type of character and inborn flair make the technical administrator, but no amount of inborn talent will make an administrator of anyone without the technical knowledge.—I am, etc.,

Cambridge. C. G. EASTWOOD.

Euflavine in Epididymo-orchitis

SIR,—When I commenced using euflavine intravenously in 1934 the methods of treating gonorrhoea in males then in use gave somewhat unsatisfactory results. It was actually in an endeavour to speed up resolution of the gonococcal urethritis that this adjuvant procedure was adopted. Neutral euflavine must of course be used, 20 ml. of an 0.25% solution in distilled water being injected intravenously in the usual way.

Unfortunately it was found that this did not favourably modify the course of the urethritis. The injection was repeated weekly for, in some cases, several months without any apparent appreciable benefit. A total of 3,560 injections was given. In no case were any untoward side-effects, immediate or delayed, noticed. Using the above dosage, excretion of the euflavine is usually completed by, on the average, the third or fourth day. I append some notes on the use of euflavine by this method in certain conditions.

Gonococcal Epididymo-orchitis.—Although euflavine gave disappointing results in an uncomplicated case, we soon found that it produced quite remarkable results in epididymo-orchitis and/or prostatitis. A series of 170 cases of epididymo-orchitis was treated by this method. The accompanying pain disappeared in about four hours, the swelling rapidly subsided, and in all cases complete clinical resolution occurred after an average of four injections. By complete clinical resolution of the epididymo-orchitis is meant that careful examination by a trained V.D. worker would fail to show any abnormality.

In this series there were 83 patients with right-sided epididymo-orchitis who received 355 injections (average 4.28 each). Seventy-seven patients with left-sided epididymo-orchitis received 313 injections (average 4.06 each), and 10 patients with bilateral epididymo-orchitis received 40 injections (i.e., 4 each). In other words, resolution occurred, on the average, after four injections, irrespective of whether the condition was right- or left-sided or bilateral. I do not know of any other method of treatment which gives comparable results in gonococcal epididymo-orchitis. Similar excellent results are obtained in gonococcal prostatitis. Its use does not appear clinically to interfere with the action of penicillin, nor is it contra-indicated when the patient is also receiving neoarsphenamine—i.e., when a patient has gonorrhoea and syphilis.

If a patient presents himself with gonococcal urethritis and also epididymo-orchitis our practice is to give him one intramuscular injection of 200,000 units of penicillin, and at the same visit he receives an injection of 20 ml. of 0.25% neutral euflavine intravenously. The penicillin very rapidly clears up the discharge, but, as the epididymo-orchitis persists, the euflavine is repeated once a week until the epididymis is absolutely normal clinically. Then, of course, the usual tests of cure are carried out.

Urethral Stricture.—We have also since 1934 treated 24 cases of urethral stricture with euflavine intravenously in the same dosage

repeated weekly. We commenced with 10 ml. of 0.25% euflavine as a precaution, but found that excretion was practically normal in speed. We increased next to 15 ml., and if the euflavine had disappeared from the urine after three to four days we again increased the dose to 20 ml., and maintained this dosage. It should be noted that all these were cases of considerable severity—i.e., they were impassable to a 6/9 curved sound, this being established during diagnostic instrumentation. Without the use of sounds such as dilators they all gradually improved as regards micturition—difficulty of urination decreased steadily—and in the case of those who had an accompanying muco-epithelial discharge this rapidly vanished. Usually after eight injections the act of micturition was completed with such inconsiderable deviation from the normal that they were able to resume their work. One case, however, required 38 injections before being fit for discharge. Another case in this series has had to have repeated courses of injections but has been working throughout the treatment.

This method of treatment possesses obvious advantages over instrumental dilatation, especially from the patient's point of view, and except for the one case referred to none of the patients in the series has returned for a further course of treatment. Presumably in this series euflavine acts by allaying the inflammatory oedema which is found especially on the proximal side of the stricture. It has, of course, no effect on the stricture as such; nevertheless, after a course of injections as described it will be found that a 6/9 curved sound passes easily without any bleeding. It is probable that it is by allaying the inflammation on the posterior urethra and in the trigone that it permits of such remarkable results in epididymo-orchitis and prostatitis.

Other Conditions.—One young man of 18, who also was a congenital syphilitic, was referred to us with a tubercular left testis. (He also had pulmonary, meningeal, and renal tuberculosis.) His left testis appeared on examination to be on the point of breaking down and fistulating. We had to proceed with caution on account of the renal condition, so we commenced with an injection of 3 ml., increased to 5 ml. the following week, and so on up to 10 ml., given twice. The testis gradually improved, and instead of breaking down became "bone hard," probably from calcification. Except for its great weight and size it caused him no further trouble. It must not be assumed that I am recommending this form of treatment for tuberculosis of the testis. I have only indicated the factual result in this particular case; the man's medical officer considered that owing to his general condition he was unsuitable for operation.

I have not had the opportunity of trying this method of treatment in cases of bacilluria, except for one case which complicated pregnancy and in which it rapidly cleared up the condition. It would seem an obvious method to try in such cases on account of its safety and freedom from any side-effects.

I confidently invite others who are interested to try this safe and simple technique, especially in gonococcal epididymo-orchitis.—I am, etc.,

South Shields. D. J. MACKINNON.

The Natural History of Asthma

SIR,—I was very interested in Dr. D. H. Irwin's remarks on the psychogenic aspect of asthma (December 10, p. 1354) and would like to make some comments. He remarks on the parent–child tension which is invariably present, and he considers that "the effective parent in the relationship is usually the mother." I would say that the mother is emotionally stable until she is confronted by the bewildering and provocative personality with which her child is endowed. The increasing demands on the mother, which are telepathic rather than vocal, and the intelligent sensitivity, which is often overcompensated, keeps the mother constantly guessing and leads to a neurosis even in the most stable.

The evidence that the child is born with a specific personality pattern is fairly convincing. The uniformity of personality traits which is seen throughout Rogerson's[1] series, and in my own observations, indicates a common genetic denominator. Also, the asthma personality may be well developed long before the child ever has an asthmatic attack. The mother may, and usually has, already reared several sibs without any undue emotional tension; it is not true that only children occur more frequently in asthmatic groups.

With an asthmatic child a good mother responds by overprotectiveness, and it is necessary to curb this, perhaps, as Dr. Irwin suggests, by group therapy. If it is the child who is the primary source of the tension, by virtue of his specific personality pattern, then would it not be rational to treat the child, or preferably a group of children, in, say, a playroom? This has already been tried, of course, with notable success by Rogerson.—I am, etc.

London, E.15. L. E. WEAR.

REFERENCE

1 Rogerson, C. H., *Quart. J. Med.*, 1937, **6**, 367.

Treatment of Wounded in Malaya

SIR,—I gather from my colleagues who served in the 1914–18 war that much of the surgical experience that was dearly bought in that war had to be gained all over again in the early years of the 1939–45 war. Those of us who served in the 1939–45 war hoped that the lessons learned would not be quickly forgotten. The Royal Society of Medicine, in convening the Inter-allied Conferences on War Medicine and in publishing these proceedings in book form, has done everything possible to ensure that the knowledge of war medicine gained should not be lost.

It is, therefore, all the more regrettable to learn from the reply by Mr. Shinwell to Mr. E. Hughes, concerning the number of surgeons in Malaya, that after less than five years so much has apparently been forgotten. The campaign in the Western Desert established the value of the field surgical unit and field transfusion unit being grouped at the main dressing station of a field ambulance with instructions to deal with "life and limb surgery." As a result of siting these units well forward, where they could deal with such cases as penetrating wounds of the abdomen and thorax and severe compound fractures of the femur, countless lives were saved. These casualties would have had little chance of survival had they been compelled to make the often tedious journey back to a C.C.S. or general hospital.

I appreciate that the problems of the jungle are not those of the Western Desert, but those of us who went from the desert to Sicily and Italy and later to Normandy found that the principles of forward surgical organization did not differ very greatly in the various theatres of war. It would appear from Mr. Shinwell's statement that there are only four Army surgeons in Malaya and Singapore Island. This number would seem quite inadequate to carry out the early surgical treatment which forms so important a part in war surgery. I sincerely hope that in a subsequent statement the Minister of War will be able to assure us that the medical services in Malaya to-day are no less efficient than in 1945; meanwhile his statement must give rise to the gravest misgivings.—I am, etc.,

Hove. REX BINNING.

With Whales and Seals

SIR,—While not unduly squeamish nor an opponent of blood sports as practised in this country—I follow hounds by car when I get the opportunity—I was nauseated when I read certain passages from Dr. H. R. Lillie's article entitled "With Whales and Seals" (December 24, 1949, p. 1467). If shortages are now so acute that human so-called civilization can only survive by the practice of such revolting cruelties on mammals that neither prey on man nor are vectors of any disease one wonders whether it is worth the while of medical science to strive towards the preservation of the fittest, let alone the unfittest.

A few days ago I read in a daily paper that a Whalemeat Advisory Bureau had been established in London. This announcement was alongside an advertisement depicting a housewife bearing a dish of whalemeat to her simpering family. The caption should have been, "Where ignorance is bliss." Why doesn't a protest come from the antivivisectionists and other individuals who take up their pens so readily on account of the indignities to which performing animals are subjected? Can it be that any of their own pampered pets are fed on whalemeat?

Slaughtering of whales and seals should be prohibited by international law until humane forms of killing have been devised and instituted. Commercial exploiters would then be stimulated to take rapid action.—I am, etc.,

Newcastle-upon-Tyne. E. T. EVERDELL.